Market Research & Consulting
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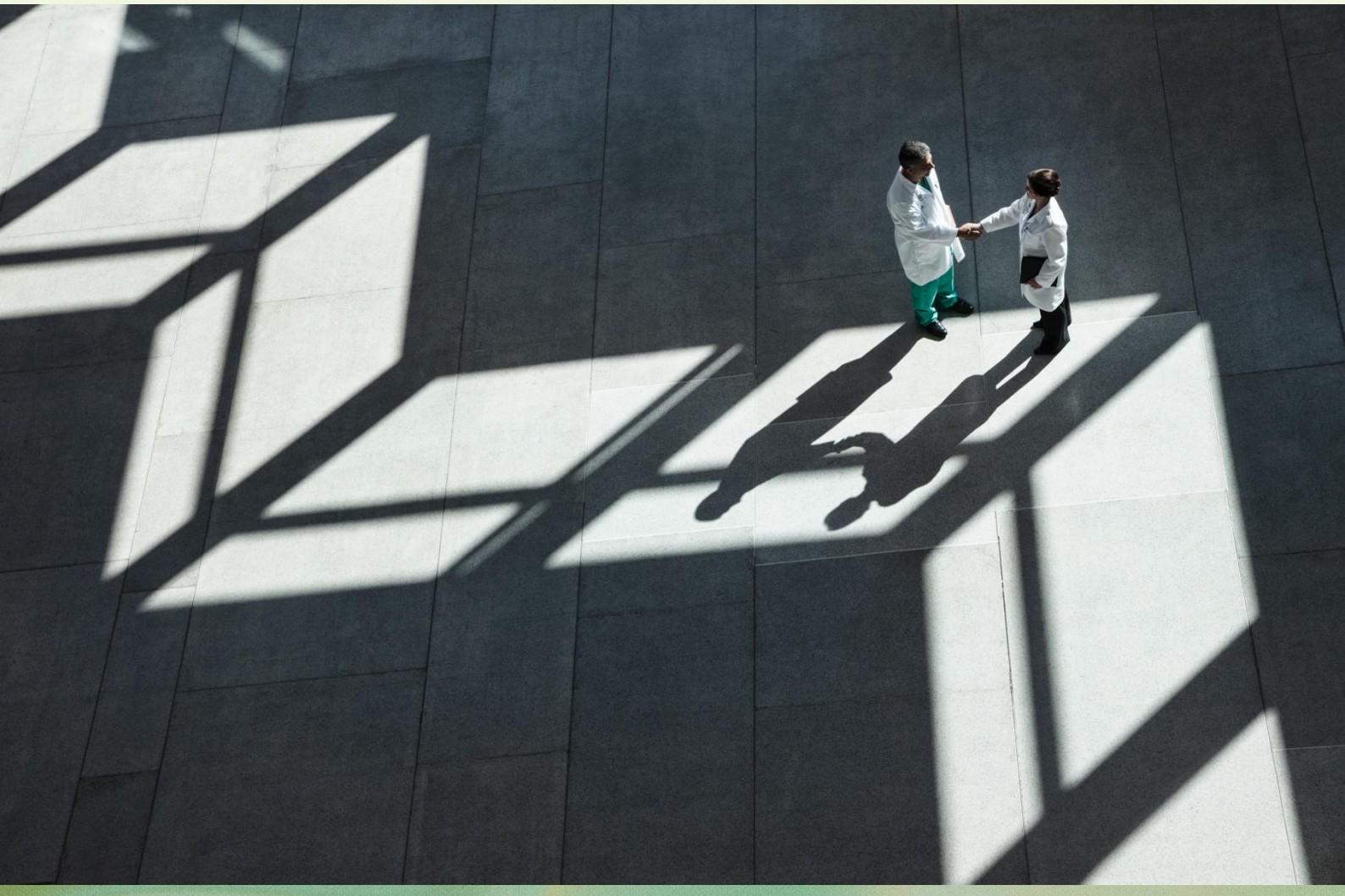
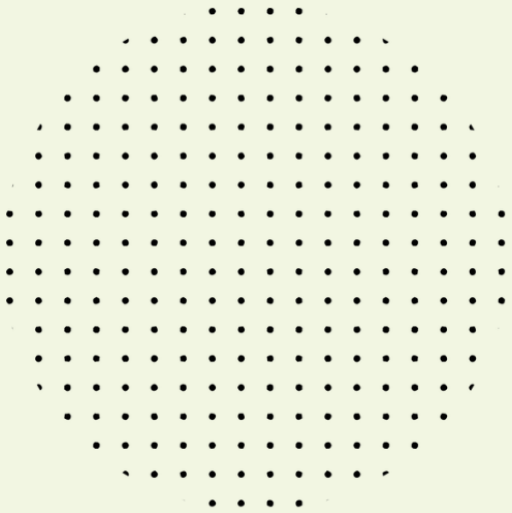
Tips for Healthcare MR in Japan

Comparison of Japanese and U.S. Healthcare Systems





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1. Roles and Responsibilities of Physicians and Nurses

In Japan, physicians carry the primary responsibility for medical decision-making, diagnoses, and treatments, similar to their U.S. counterparts. However, the delegation of tasks to non-physician providers is less common in Japan. Advanced practice roles like nurse practitioners (NPs) are relatively new and limited in scope. Japan only began training NPs in 2008, and under current law they must work under physician supervision and **cannot independently assume the same responsibilities as doctors**. This contrasts with the United States, where many states allow NPs more autonomy in primary care. Likewise, the physician assistant (PA) role does not exist in the Japanese system at all meaning doctors in Japan often perform clinical tasks that PAs or NPs might handle in the U.S. Nurses in Japan (registered nurses or "kangoshi") provide bedside care, patient monitoring, and education, much as nurses do in the U.S. They do not typically have prescribing authority or perform advanced procedures without direct physician orders. Specialized nursing roles (e.g. nurse anesthetists or nurse midwives) are limited. Overall, **Japanese physicians tend to have a heavier workload of patient care tasks** due to the lack of mid-level practitioners. For example, Japanese doctors often handle procedures and administrative duties that might be delegated elsewhere, contributing to long working hours. In hospitals, nurses focus on patient support and coordination, but any extension of nursing practice (such as the new NP training programs) is seen as *"task shifting"* to alleviate physician workload rather than independent practice. The result is a more physician-centric model of care delivery in Japan, whereas American healthcare teams commonly incorporate NPs, PAs, and other providers to share duties.

2. Differences in Medical Specialties and Practice Patterns

Japan's approach to medical specialization and daily practice patterns differs from the U.S., often in response to its healthcare system's structure. **Japanese physicians generally maintain a broader scope of practice**. Many specialists in Japan are trained as generalists first and may continue providing general care even as specialists. It's common for a Japanese doctor to manage a wide range of issues within their field and even perform procedures (e.g. minor surgeries, imaging interpretation) themselves. This stems in part from a training culture that emphasizes "professional commitment" and skill breadth – Japanese residency has *no strict work-hour limits and encourages developing broad clinician skills (including doing bedside procedures and reading radiology imaging.)*

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By contrast, U.S. training prioritizes work-life balance and often **compartmentalizes care**, with clearer division of roles (specialists focus on narrower scopes, and duties can be handed off to other team members.) One direct effect of Japan's system is the **high patient volume per physician**. Because patients can see specialists directly and healthcare visits are inexpensive (due to insurance, discussed below), doctors in Japan see far more patients on average. In fact, Japanese physicians handle *over three times as many outpatient visits per year* as U.S. physicians on average. This often translates to very short consultation times (Japan is known for the "three-minute consultation" phenomenon). While patients enjoy easy access, doctors face an **extremely high workload** under these conditions. American physicians typically have longer visits and fewer total patient encounters, partially due to appointment-based systems and the gatekeeping role of primary care.

Practice patterns also differ in how care is organized. The concept of a *family physician* or general practitioner as the first point of contact has only recently gained traction in Japan (see Section Appendix). Historically, **patients in Japan freely visit any clinic or hospital of choice**, including tertiary hospitals, without a referral. This can lead to crowded hospital outpatient departments and sometimes fragmented care. By comparison, U.S. practice patterns often route patients through primary care and referrals, which Americans are accustomed to, but would be unfamiliar in Japan's open-access context. Japanese hospitals are also more likely to separate patients by specialty departments or diagnosis (e.g. wards dedicated to a specific disease), reflecting a tradition of organ-specific care. Meanwhile, clinics in Japan are typically physician-owned small practices that provide both primary care and some specialty care. It's not uncommon for a Japanese specialist (say, a cardiologist) to also serve as a general practitioner for walk-in patients, which **differs from the more siloed U.S. specialist** who usually sees patients by referral for specific issues.

Finally, the culture of medicine in Japan places a strong emphasis on harmony and authority of the senior physician. Decisions may be less frequently questioned by junior staff or patients than in the U.S., though this is gradually changing. Doctor-patient communication styles can differ – for example, Japanese consultations historically were more physician-driven and less explicitly communicative about risks, whereas U.S. practice encourages patient involvement and detailed informed consent discussions. These subtle cultural differences influence how care is practiced day-to-day, and U.S. researchers should be aware that what is standard in American settings (like frank discussions or aggressive questioning of superiors) might not be the norm in Japan.

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3. Health Insurance Systems and Impact on Care

Japan's health insurance system is a universal coverage model that stands in contrast to the mixed public-private system in the U.S. Every resident of Japan is covered by the Statutory Health Insurance System (SHIS), which includes employee health plans and National Health Insurance for others, ensuring no one is uninsured. As a result, access to basic healthcare is virtually guaranteed for the population. In practical terms, this means Japanese patients can seek care without worrying about losing insurance coverage (a common concern in the U.S.) and out-of-pocket costs are generally limited to 30% of the fee (with monthly caps for high costs).

One important aspect is that Japan uses a uniform fee schedule for medical services and prescription drugs nationwide. The government, through the MHLW, sets the price for every consultation, procedure, and product. These fees are often much lower than equivalent prices in the U.S., and they are adjusted periodically to control spending. Consequently, Japan's total health expenditure as a share of GDP is about two-thirds of the United States, yet health outcomes (like life expectancy and infant mortality) are overall better in Japan.

Cost containment via fee control does have side effects: providers in Japan compensate for low fees with high patient volumes and frequent services. The average Japanese citizen visits a doctor about 14 times a year, compared to about 3 visits per year for an American. This high utilization includes frequent check-ups and follow-ups, and also a high usage of diagnostics. Since simple tests and imaging are cheap under the fee schedule, Japanese doctors tend to order more tests (e.g. frequent CT scans or bloodwork) as part of routine care. While this can lead to early detection of issues, it is also sometimes described as excessive use of diagnostics by U.S. standards.

In contrast, the U.S. insurance landscape (with Medicare, Medicaid, employer insurance, and uninsured populations) leads to large variations in access and cost. American researchers will be familiar with issues like pre-authorizations, out-of-network costs, and uninsured patients – none of which apply in Japan's egalitarian system. There are no insurance "payors" or gatekeeping insurance companies in Japan; the concept of private insurers managing care or reimbursing

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differently doesn't exist. All reimbursement comes from the national system, so administrative overhead is lower and billing is simpler (in one standard format). For pharmaceutical and device companies, this means pricing and market access are largely determined by national policy rather than negotiations with many private insurers.

The insurance setup in Japan also impacts patient behavior: with minimal financial barriers, patients often seek care for minor issues and can shop around at different providers. This open-access approach, coupled with no requirement to register with any primary doctor, can lead to overcrowding in popular urban hospitals. For example, a large university hospital in Tokyo may have long wait times because patients come directly without referrals even for mild conditions. As one observer noted about Japan, "You can go see a specialist without a referral; it's more accessible, but there is less likelihood of being seen since it's so accessible." In other words, open access sometimes results in patients waiting or being deferred if the facility is over capacity. Japan has implemented small disincentives (like extra fees) for patients who bypass clinics to go straight to big hospitals, but the culture of open access remains strong.

In summary, Japan's universal insurance provides stable coverage and influences care towards high volume, low cost-per-service delivery. Preventive care and early treatment are encouraged, and there are few financial disincentives for patients to consult a doctor. For U.S. researchers, the key takeaway is that Japanese healthcare is not constrained by insurance networks or variable pricing, but instead by system capacity and the nationwide policies that set what is covered and how care is reimbursed. This leads to a different pattern of service usage and makes the healthcare business environment in Japan quite distinct from the U.S.

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4. Authority over Purchasing Medical Devices and Equipment

When it comes to buying medical equipment and devices, decision-making authority in Japan is often structured through hospital administration and long-standing distributor relationships rather than individual physician preference alone. Most hospitals and clinics in Japan procure devices via a “hospital-linked dealer”, a dedicated distributor that supplies most of their equipment. Physicians certainly influence what clinical tools they need, but the process is mediated by these distributors and hospital management. The relationship between Japanese doctors and device distributors is traditionally very close-knit – often a particular dealer has served a hospital for years, developing trust with the physicians. This tight relationship can sometimes lead to less competitive pricing or a de facto monopoly for that dealer within the hospital. Manufacturers cannot independently set the final sale price to hospitals due to regulations (resale price maintenance is prohibited), so they must work through distributors who negotiate with hospitals.

In practical terms, a Japanese department chief who wants a new piece of equipment (for example, an MRI machine or surgical robot) will usually work with hospital executives and their affiliated dealer to evaluate and acquire it. Public hospitals in Japan, in particular, are often required to use public tendering for major purchases, adding another layer of administrative control. Private hospitals have more leeway, but even then, they typically stick with their preferred vendors. Physicians in Japan do not usually have independent budgets to buy equipment; the purchases go through the institutional budget and approval process. This is somewhat similar to U.S. large hospitals that use capital budget committees, but one difference is the lack of group purchasing organizations in Japan. Instead of GPOs that aggregate purchasing for many hospitals (common in the U.S.), Japan’s system relies on the distributor network. There are around 2,400 medical device distributors in Japan, and they interface directly with both clinical decision-makers (doctors) and non-clinical decision-makers (hospital admins) at healthcare facilities. Each distributor often handles a range of products and may act as the local agent for multiple manufacturers.

For example, a Japanese hospital’s cardiology department might obtain stents and catheters through their appointed distributor. The cardiologists can request certain brands or models, but the negotiation and ordering are handled by the distributor in consultation with hospital purchasing staff. The distributor often provides device demos, coordinates trials, and then fulfills the order, bundling it with the hospital’s other supply needs. This one-stop distribution model

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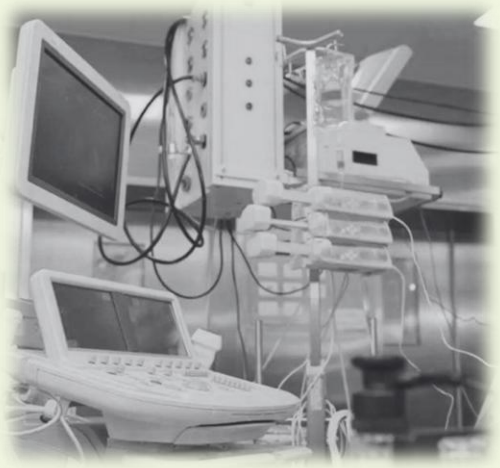
contrasts with the U.S., where hospitals might source directly from manufacturers or via GPO contracts for better pricing. In fact, nearly all U.S. hospitals use GPOs and centralized purchasing for most supplies, whereas Japanese hospitals mostly stick to their few chosen dealers and expect those dealers to deliver a broad range of products.

It's also worth noting that Japanese physicians at private clinics (solo practices) have authority when they are owners of their clinic – they can decide to purchase diagnostic devices (like an ultrasound machine) for their clinic. Even then, they will typically go through a medical equipment dealer for the transaction and maintenance. The dealer often assists with installation and after-sales service, which fosters loyalty. Because the national fee schedule determines reimbursement for device-related procedures, Japanese clinics think carefully about return on investment; a device that isn't reimbursed well may not be worth purchasing. In the U.S., a physician owner might buy an expensive device if they anticipate a competitive advantage or higher billing, but in Japan the incentive is tempered by fixed low reimbursement.



For U.S. researchers, the key differences are: (a) the absence of independent physician purchasing outside of organizational budgets, (b) the central role of distributors in device supply, and (c) regulatory and pricing structures that make device acquisition a more uniform process nationally. While an American surgeon might lobby their hospital for the newest surgical robot and seek funding or donations to get it, a Japanese surgeon would typically rely on the hospital's capital planning process and their distributor's proposal, all within the confines of government-set pricing and tender rules. This can affect the pace of technology adoption – Japan has many high-end devices (it actually leads in per-capita MRI and CT scanners), but those tend to be distributed across hospitals in a somewhat uncoordinated way, since each institution decides on its own investments (hospitals "are allowed to purchase any equipment and open any specialty department" they choose under law). The lack of a unified regional planning means there might be duplication (several hospitals in one city each buying similar equipment). It also means that device market research in Japan often involves understanding the distributor networks and hospital decision hierarchies, rather than negotiating with insurance or large health systems as in the U.S.

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5. Conducting Pharmaceutical/Healthcare Market Research in Japan

When planning pharmaceutical or healthcare market research in Japan, researchers and clients should be aware of several unique cultural and structural factors. These factors can affect everything from recruiting the right experts to the format of interviews and the level of engagement you can expect. Below are some key insights and tips, including examples like the difficulty of physician focus groups due to hierarchy, differences in specialty definitions, preferred interview styles, and incentive expectations in Japan:

Hierarchy and Group Interviews:

Japan's culture of hierarchy and group harmony can pose challenges for focus group research, especially among physicians. **Japanese doctors are very conscious of seniority and pedigree**. In a group setting, participants may be reluctant to voice dissenting opinions or contradict a more senior or more prestigious colleague. For example, if you conducted a focus group of physicians, the opinions of a doctor from a top university or the oldest doctor in the room might dominate, and others would defer instead of offering their true thoughts. As one market research expert notes, in Japan the responses of the physician who graduated from the "best" university will influence the others in a focus group, so you may not get independent feedback. Culturally, Japanese participants tend to avoid open conflict or direct criticism in group discussions, valuing group cohesion and saving face. It is often difficult to get participants to openly disagree or criticize in a group. Because of this, a strong recommendation is to conduct individual in-depth interviews (IDIs) rather than focus groups when researching with HCPs in Japan. One-on-one interviews make Japanese physicians much more comfortable sharing honest opinions, free from peer influence. If group sessions are necessary, it's wise to group participants of **similar age/title and avoid mixing senior with junior people**. Indeed, best practice in Japan is sometimes to not even disclose or ask ages in a group setting to prevent any hierarchy from forming. Also, giving participants a moment to write down thoughts before sharing (to mitigate the instinct to simply echo others) can help elicit more candid input.

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Differences in Specialty Definitions and Recruiting the Right Experts:

It's crucial to understand that medical specialties in Japan may not align one-to-one with those in the U.S. Titles can be different, and the scope of practice can vary. For instance, if an overseas client wants to do research on "oncologists" for a breast cancer treatment, in Japan the relevant experts might not be called oncologists at all – you'd likely need to speak with breast surgeons. **Japan historically has fewer medical oncologists;** breast cancer care has been handled by surgeons (often in a hospital's breast surgery department). These surgeons perform surgery but may also prescribe anti-cancer drugs, a role that a medical oncologist would fill in the U.S. Similarly, many subspecialties are organized differently. When recruiting, one should consult local classifications: for example, Japan has a specialty of "Respiratory Medicine" (pulmonologists) who might treat lung cancer alongside surgeons, and "Gastroenterology" specialists treat GI cancers – so depending on the research topic, you might need to include those specialties rather than an "oncology" title. Another difference is in primary care: Japan only recently formalized General Practice/Family Medicine as a specialty, and traditionally patients see internal medicine doctors or organ specialists for primary care needs. If your study is about primary care or general practitioners, you may find that clinic-based internal medicine physicians are the closest equivalent in Japan. Always verify the Japanese medical terminology for the target specialist. Engaging a local partner or advisor is valuable to map U.S./EU roles to Japanese counterparts (for example, understanding that a "耳鼻科" doctor is an ENT specialist, or that "循環器内科" covers cardiology). In summary, **ensure you're recruiting the correct segment of Japanese physicians**, which might be defined by disease area or department (e.g. "diabetes specialists" in Japan could be endocrinologists or general internal doctors with a diabetes focus, since board-certified endocrinologists are fewer per capita). Misalignment in specialties could lead to interviewing the wrong experts and gathering misleading insights.

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Interview Style and Communication:

Conducting interviews with Japanese healthcare professionals requires a culturally sensitive approach. **Direct confrontation or aggressive questioning should be avoided.** Polite, respectful dialogue is expected, and interviewees may be hesitant to openly criticize or to say, "I don't know." A concept in Japan called "空気を読む (read the air)" underscores the importance of social context – akin to "reading the room". A skilled moderator who understands Japanese etiquette can gently probe for answers in a non-confrontational way. **Silence is not uncommon;** a Japanese interviewee might pause longer before answering (they are likely formulating a considered response). The moderator should be comfortable with these pauses and not rush to fill them. It's also beneficial to avoid overtly leading questions that could be perceived as too direct. Instead of asking "Why do you do X? Isn't it better to do Y?", one might ask in a softer tone, "How do you feel about X approach versus Y? What are the considerations for you?" Moreover, language is a factor: while some Japanese doctors can speak English, most prefer Japanese for nuanced discussions. Whenever possible, **conduct the interview in Japanese with professional interpretation** for the client, rather than forcing the physician to speak English. According to experienced researchers, requiring English can severely limit who participates and may lead to shallow answers. Japanese physicians will generally be far more expressive in their native language. Ensuring consent forms, discussion guides, and stimulus materials are translated appropriately is also key. Additionally, demonstrating respect – for example, using appropriate titles (like "Dr. ___" or "Sensei" in Japanese context) and a courteous tone – will help build rapport. Unlike in some Western contexts where interviews can be somewhat casual, in Japan a bit of formality is appreciated. Yet once a good rapport is established, Japanese interviewees often provide very thoughtful, detailed insights. In summary, **be patient, polite, and culturally aware in interview style,** allowing the respondent to share thoughts in a non-pressured atmosphere.

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Incentive Expectations and Logistics

Offering incentives (honoraria) to healthcare professionals for market research participation is standard practice in Japan, as in other countries, but there are a few nuances. Japanese physicians expect to be compensated for their time with honoraria roughly comparable to global rates (though the exact amount can depend on specialty and rank – e.g. a senior specialist might command a higher incentive). One notable practice in Japan is that **research agencies are extremely careful about cancellations and no-shows.** It is considered very impolite to cancel an interview on short notice because the doctor likely arranged their busy schedule to participate. If a client or researcher cancels last-minute, agencies will often pay the physician the full honorarium regardless. This is seen as a professional courtesy to avoid causing offense or discouraging them from future research. In fact, M3 (a global research panel provider) notes that they make it a point to still pay doctors if a session is canceled late, to maintain goodwill. Overseas clients might be surprised by this policy, but it speaks to the importance of respecting the physician's time in Japan. Another logistical point: Japanese doctors (especially hospital-based) are extremely busy during the day – their working hours often extend into the evening. Therefore, **scheduling interviews after hours (post 7 PM local time on weekdays, or on weekends)** is often necessary. It's not unusual to conduct an interview at 8 or 9 PM Tokyo time once the doctor has finished seeing patients. Planning for time zone differences is important for overseas teams in these cases. In terms of honorarium delivery, many Japanese physicians prefer bank transfers or vouchers; cash can be acceptable in person (in an envelope as per Japanese custom), but nowadays transfers are common. There are also guidelines (JMRA) in Japan about honoraria limits to ensure they are reasonable and not construed as improper payments, so working with a local fieldwork agency can ensure compliance.

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Additional cultural tips

Building trust is vital. Japanese participants may be a bit reserved initially. Often a few minutes of polite small talk (or explanation of how their feedback will be used to improve patient care, etc.) can put them at ease. Showing that you are knowledgeable about Japanese healthcare context (for example, acknowledging "In Japan, I know the system is like X… we're here to learn how you do ___ in your practice") can earn respect. Also, confidentiality is crucial to mention – assure them that their personal identity or any opinions won't be reported back to, say, their hospital or superiors (this is standard in market research, but given the hierarchical environment, it helps them speak freely when they know their comments are anonymous). Lastly, **be prepared for modesty** – Japanese doctors might understate their accomplishments or opinions ("This is just my humble opinion…"), so encourage them that all insights are valuable. When asking about treatment habits or patient numbers, you might get conservative estimates due to modesty or uncertainty; sometimes asking in ranges or asking about the most recent case they handled can get more concrete data.

In summary, conducting healthcare/pharma market research in Japan requires thoughtful adaptation to cultural norms. Key takeaways for overseas clients: **prefer one-on-one interviews to group discussions** to get frank opinions free of hierarchical influence; ensure you're recruiting the correct **specialists given Japan's unique physician roles** (what's standard in the U.S. might be a different title in Japan); use a **skilled moderator/translator** to navigate language and etiquette so that respondents feel comfortable sharing (debate and direct criticism are muted in Japanese culture, so questions must be phrased accordingly); and plan for **logistics/incentives** that respect the physicians' time and customs (schedule conveniently, compensate fairly, and maintain professionalism). By understanding these nuances, one can obtain rich and reliable insights from Japan's healthcare experts, which will ultimately lead to more successful research outcomes and strategies in the Japanese market.

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6. Differences in Specialty Recognition: Subspecialties in Japan vs. Standalone Specialties Abroad

In Japan, the definition of medical specialties can differ significantly from the U.S. and other countries. Several fields that are considered independent specialties with their own training and boards in the U.S. (or elsewhere) are **not separate board-certified specialties in Japan** – instead, they exist as subspecialties or are handled by other departments. Below are some notable examples and explanations of these differences:

- **Nuclear Medicine:** In Japan, nuclear medicine is typically a subspecialty under the Department of Radiology. Most doctors who perform nuclear medicine studies (like PET scans or thyroid scans) are radiologists by training, rather than dedicated nuclear medicine physicians. Academic radiology departments in Japan often include a Nuclear Medicine division rather than having a separate nuclear medicine department. In contrast, the U.S. recognizes Nuclear Medicine as a distinct specialty with its own residency; U.S. "nuclear physicians" may come from radiology or other backgrounds but get separate certification. The Japanese approach means radiologists cover everything from CT/MRI to nuclear imaging. This integrated model can impact practice – for instance, radiologists in Japan might interpret PET scans and also read conventional images, whereas in the U.S. a nuclear medicine specialist would focus on those scans exclusively.

- **Interventional Cardiology:** In many countries, interventional cardiology (catheter-based treatment of heart disease, such as angioplasty and stenting) is a specialized track within cardiology with additional fellowship training. Japan does have cardiologists who specialize in interventions, but there is no separate certificate; interventional cardiology is considered part of general cardiology practice. In Japan, a physician will become a cardiologist (through internal medicine specialization and cardiology training) and then perform cardiac catheterizations and interventions as part of their job if they choose that focus. There isn't a distinct title like "Interventional Cardiologist" versus "Cardiologist" – they are all just cardiologists, often with on-the-job or short-term training for interventions. By comparison, in the U.S. a cardiologist would typically undergo an extra interventional cardiology fellowship and become board-certified in that subspecialty.

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Japanese cardiology units in large hospitals handle interventions without calling in a different specialist, although sometimes radiologists or surgeons may assist for complex cases. The net effect is that **cardiac interventions in Japan are firmly within the domain of cardiologists**.

- **Pain Medicine:** Japan does not recognize Pain Medicine as an independent specialty. **Chronic pain management is usually handled by anesthesiologists or orthopedic surgeons** (and sometimes neurosurgeons or physiatrists) who have an interest in pain. Many hospitals have "Pain Clinics" often staffed by anesthesiology departments, focusing on treatments like nerve blocks, epidural injections, and management of chronic non-cancer pain. Orthopedic surgeons may manage musculoskeletal pain with interventions or medications as part of their practice. In the U.S., Pain Medicine is a multidisciplinary specialty (with formal fellowships for anesthesiologists, neurologists, physiatrists, etc., and board certification). The Japanese model means a patient with chronic back pain might see an orthopedist or anesthesiologist for pain relief; there isn't a separate pain specialist directory. This can sometimes lead to variability in pain treatment approaches, and historically, Japan has been viewed as more conservative in pain medication use (cultural factors also play a role). Efforts are underway to improve pain management in Japan, but it remains embedded in other specialties rather than a standalone field.

- **Palliative Care:** Palliative medicine is an emerging field in Japan, primarily driven by the hospice movement and cancer care needs. The Japanese Society for Palliative Medicine has established a board certification system (since 2010) to train and certify palliative care physicians. However, the number of specialists remains small – as of 2019 there were only about 530 certified palliative physicians in the entire country. This is far below what is needed nationwide, so in practice many patients receive palliative care from their oncologist, primary care doctor, or hospital physicians without a palliative specialist. Some large hospitals and cancer centers have palliative care teams, but it's not yet a standard presence everywhere. In the U.S., Hospice and Palliative Medicine is an established subspecialty (with many hospitals having consult teams and specialists available).

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Japan is catching up, but slowly: palliative care is still often provided by whichever doctor is in charge of the patient, sometimes with informal consultation from a small palliative team. The recognition of the field is growing, with more training programs and a push to certify more doctors. Still, U.S. researchers should note that outside major centers, a Japanese "palliative care" doctor might simply be the oncologist or internist who took on that role, rather than someone who had a dedicated fellowship.

- **Geriatrics:** Despite Japan's famously old population, Geriatric Medicine as a specialized field is underdeveloped. There is a certification offered by the Japan Geriatrics Society, but only around **1,600 geriatricians are certified in Japan – about 0.4% of all physicians**. Most Japanese medical schools do not have a geriatrics department, and geriatric training is usually just a part of general internal medicine. Essentially, the care of elderly patients is handled by internists, family physicians, or organ-specific specialists. For example, an 85-year-old with multiple chronic conditions might see a cardiologist for heart failure, an orthopedist for knee arthritis, and so on, rather than a single geriatrician coordinating care. In the U.S., Geriatric Medicine is a recognized subspecialty (internists or family doctors can become board-certified geriatricians), and geriatric assessment clinics are common. Japan is beginning to acknowledge the need for more holistic elderly care – geriatric medicine was added to the official specialty list only recently – but it **lacks a robust geriatric care infrastructure**. The result is often polypharmacy and multiple specialist visits for Japanese seniors. There is growing interest in improving geriatrics, especially as the government recognizes the strain of an aging society, but for now geriatricians remain few, and many physicians treating older adults do so without specialized geriatric training.

- **Emergency Medicine:** Japan does have Emergency Medicine as a specialty, but it is not as uniformly implemented as in the U.S. The Japanese Association for Acute Medicine certifies emergency physicians, and the specialty has grown since being introduced a few decades ago. Still, the workforce is limited: **as of 2025 Japan had only around 6,123 board-certified emergency physicians** (for a population of 123 million), compared to over 25,000 in the U.S. for a population of 330 million. Many hospitals, especially smaller or rural ones, do not have

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dedicated emergency physicians at all. Instead, they operate on a **multi-specialty staffing model** – for example, at night the emergency department (ED) might be covered by whichever internist or surgeon is on call, rather than a full-time ER doctor. Large urban hospitals do maintain 24/7 emergency specialists (and Japan has outstanding tertiary trauma centers), but the system is not consistent nationwide. Emergency Medicine in Japan also covers a slightly different scope: some emergency physicians have additional training in critical care, trauma surgery, or pediatrics, and they often handle intensive care unit duties or ward duties too. In the U.S., by contrast, virtually every ER is staffed by residency-trained emergency physicians or supervised mid-level providers, and there's a standardized approach to emergency care. In Japan, **the level of emergency care can vary**: some places have top-notch ER teams, while others rely on the collaborative efforts of various specialists. The government has a three-tier designation for emergency hospitals (primary, secondary, tertiary ER facilities) and is working to improve standardization. For researchers, this means that talking about "emergency medicine physicians" in Japan could refer to a smaller group of specialists, and some acute care, especially in less populated areas, might be delivered by doctors whose primary specialty is something else (e.g. an orthopedic doctor handling weekend emergency calls).

7. Primary Care Physicians (PCPs) in Japan: Concept and Practice

Japan's healthcare system does not have a formal primary care physician (PCP) gatekeeper role as understood in the United States. There is *no requirement for patients to register with a PCP*, and there is no strict referral system compelling patients to see a general doctor before consulting a specialist. In essence, the term "PCP" is not a widely used concept in Japan. Instead, **primary care is provided mostly by clinic-based physicians**, often those trained in internal medicine or sometimes in pediatrics for children, who serve as generalists in the community. These doctors are usually not labeled as "family physicians" or "general practitioners" in the traditional sense, though that is changing slowly.

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Historically, a typical scenario is that a community has a small clinic run by an independent doctor (say, *Suzuki Internal Medicine Clinic*). Locals might go to Dr. Suzuki for common ailments, check-ups, and chronic disease management. Dr. Suzuki is effectively their primary care doctor, but he might not have formal training in family medicine – he could be an ex-hospital internist or even a subspecialist who opened a general clinic. Patients are *not obligated* to see him first; they might also go directly to a hospital outpatient department for, say, a skin rash or a headache. This **open-access culture** means many people in Japan will have a preferred clinic or doctor for general issues, but they view it as a matter of convenience, not a regulated first-contact system. In fact, a large survey indicated that while Japan lacks an official gatekeeper system, about half of adults do report having a regular physician they consider their first contact. It's just not enforced by policy.

In recent years, Japan has **introduced "General Practice" as a recognized specialty** (also called comprehensive or family medicine). The Japanese Medical Specialty Board formally added general practice/family medicine in 2018 as a new specialty. Prior to that, the Japan Primary Care Association had been certifying family physicians since 2009. These moves are creating a cadre of doctors specifically trained in primary care. However, the numbers are still small (only around 1,100 board-certified family doctors as of 2022, which is 0.3% of physicians). The "General Practice" specialists often work in clinics or as hospital generalists and are trying to establish the concept of coordinated primary care. But for now, this is an evolving field. The majority of primary care in Japan is still delivered by *non-specialist primary care doctors* – essentially, any internal medicine doctor can fill that role.

Patients have complete freedom of doctor choice. This means a patient can see a primary care clinic one day and self-refer to a specialist the next. There is usually no need for a referral letter, except some big hospitals charge extra if you come without one (to encourage using clinics first). Even with that, patients can and do go directly. For example, a person with a mild skin condition could choose to visit a dermatology clinic directly, bypassing any generalist. The upside of this system is convenience and quick access to specialists. The downside is potential lack of coordination: there is no single PCP who oversees all of a patient's care by

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default. Communication between specialists and the local clinic is not automatic; it relies on the patient to bring letters or for doctors to correspond, which doesn't always happen.

That said, many Japanese do develop a relationship with a trusted local doctor who effectively acts as their PCP. Especially in smaller towns or among the elderly, people might consistently visit one clinic first – that doctor manages most issues and only refers them to hospitals when necessary. It's a de facto family doctor system, just not mandated. The government has been encouraging this by promoting "clinic-hospital cooperation" schemes and educating the public to use primary care clinics appropriately. General Practice as a new specialty is expected to grow and bolster primary care services across Japan. Also, nurse practitioners (still few in number) might in the future support primary care doctors to ease the burden.

For an American researcher, the key points about Japanese primary care are: (1) No formal PCP gatekeeper, patients are free to self-refer; (2) Primary care is usually delivered by general internal medicine physicians at small clinics; (3) A new push for family medicine is underway, but it's not yet widespread; (4) You won't find the term "PCP" used commonly in Japan – the closest is "clinic doctor" or just the person's specialty (internal medicine doctor) who serves that role. As a result, when designing programs or research that involve "primary care physicians" in Japan, one might need to target internal medicine doctors broadly, including those in outpatient clinic practice. And when considering care coordination or patient pathways, remember that a Japanese patient can directly see any specialist, which changes how interventions (like referral patterns, specialist access, or patient education initiatives) might be implemented compared to the more structured U.S. primary care system.

Overall, understanding these nuances in specialties and primary care will help U.S.-based researchers properly interpret Japanese healthcare contexts and avoid assumptions. What is a given in the U.S. (like calling 911 and always getting an ER physician or expecting a referral chain from family doctor to specialist) may not hold true in Japan. Each system has its own logic shaped by history, policy, and culture, and these differences are exactly why comparative insights can be so valuable.

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